Mental Health for the Community

Principles to underpin effective mental health service delivery to the community, February 2012

working with the community
Purpose

This document outlines principles that underpin the effective delivery of mental health services to the community. The document suggests key strategies that must be implemented to meet the needs of the population affected by mental illness in Australia and New Zealand in a coordinated and integrated manner. This document will be used to inform the development of College policy and resources that will assist with implementing these principles into practice. The document will be shared broadly with the membership and external organisations to contribute to debate and help inform the future direction of mental health services in Australia and New Zealand. It will also inform College activity to define and delineate the role of psychiatrists in current and future circumstances. It is anticipated that this will highlight the need for changes in practice and consequently the RANZCP program training.

The principles outlined in this document are designed to be broad ranging in respect of the system, settings and population groups to which they refer. Appropriate bicultural and multicultural perspectives must be considered as part of the broad implementation. It is expected that Aboriginal, Torres Strait Islander and Maori perspectives and culture form integral part of these underlying principles which should be engrained in the practice of all those working with these populations and adapted, as appropriate, to reflect cultural beliefs and empowerment.

1. Community Mental Health Forum

A Community Mental Health Forum, a joint initiative of the Royal Australian and New Zealand College of Psychiatrists' (RANZCP) Policy Development Working Group and Board of Practice and Partnerships (BoPP), was held in Melbourne on 24 June 2011.

The Forum was developed to better position the College to be able to respond to, and lead the debate on the major changes currently taking place in the organisation and the delivery of community mental health services in Australia and New Zealand. The Forum agreed on the following goals:

- Define what community means in the context of psychiatric care;
- Avoid a document that responds only to the current political-policy environment and events.
- The document should be less prescriptive and more a presentation of key principles for consideration; and
- Achieve consensus on 10-12 principles.

The document would be circulated for input from the broad membership before being forwarded to BoPP for its endorsement. It would then be submitted to General Council for its approval.

A key document informing the Forum was the “Community Mental Health Forum” Briefing Paper – 24 June 2011, which is available on request. Forum participants, listed in Appendix 1, included psychiatrists from the public and private sectors and service user and carer representatives.
2. The Emerging Mental Health Landscape

There are a number of very substantial changes taking place in mental health policy and practice in Australia, New Zealand and internationally that have significant implications for the way that specialist mental health services are delivered and for the practice of mental health professionals, including psychiatrists. These changes include:

1.1 Personal recovery: Looking beyond clinical recovery and measuring the effectiveness of treatments and interventions in terms of the impact of these on the things that matter to individuals as they try to find new meaning and purpose in their lives.

1.2 Person-centred care: There is a call for transformation of the health system away from a model of health care that is uniform and professionally driven to one that is more individually tailored and based on partnership between individuals, families and professionals. With people having increased responsibility for their own health and wellness, sufficient attention should be given to the positive benefits of promotion of self care strategies and opportunities there is also an expectation that many service users may contribute through peer support frameworks to others’ recovery.

1.3 Structural changes: Medicare Locals [ML] and Local Hospital Networks [LHN] are being rolled out across Australia as part of a national healthcare reform strategy. The former will constitute a nation-wide network of primary health care organisations to support health professionals and improve the delivery of primary care services at a local level. LHNs, made up of small groups of hospitals that will work together to establish a range of services, are being established across the country. They will be run locally manage their own budgets and be paid directly by the Australian Government for each public hospital service they provide. There is still much uncertainty about how these new arrangements will function and the impact that they will have on the mental health service system.

1.4 Primary mental health care: Both New Zealand and Australia have put considerable effort into strengthening the capacity of the primary health care sector to promote mental health and wellbeing and to respond to the needs of people with mental illness. Under Te Kokiri: the Mental Health and Addiction Plan 2006-2015, the New Zealand Government has been building the capacity of primary care practitioners to be able to manage the needs of people with mild to moderate mental health problems in primary care settings.

The Increased Access to Psychological Therapies [IAPT] program developed in the United Kingdom has seen the introduction of a totally new class of worker, the Psychological Well-being Practitioner, into the primary care setting aimed at providing low intensity Cognitive Behaviour Therapy to people with mild to moderate anxiety and depression. beyondblue has been seeking to pilot a similar model in Australia. Little cognizance has been given to the complexity of introducing this model into a very different health care environment.

1.5 Workforce changes: As Dr Lyndy Matthews, the then Chair of the New Zealand National Committee, wrote earlier this year “Australia and New Zealand Face similar challenges over the next 5 to 10 years ....... where the move is towards mental health work being done by primary care, NGO sector and allied professional groups.” In Australia, programs such as Access to Allied Psychological Services [ATAPS] and Better Access, have seen the growth of allied health services within the private sector. Strong growth in the community sector [NGO] is already underway in many jurisdictions, with a strong commitment from a number of Governments for further significant investment.
There is also a growing recognition that service users and carers can play an important and more active role, not only in self-management of mental illness, but in policy development, planning and service delivery.

New roles have and will continue to develop within the mental health system. Some examples of roles are Personal Helpers and Mentors, Nurse Practitioners, Peer Professionals/Support Workers, Aboriginal Mental Health Workers, employment counsellors. Health Workforce Australia has signalled potentially far more sweeping changes.

1.6 New ways of working: People living with mental illness require access to a range of services to strengthen their community engagement and improve their quality of life. Such services include housing, education, employment and training, disability support and general health services. It is being increasingly recognised that a whole of government approach is required.

Technologies such as video-conferencing and on-line services are becoming increasingly recognised as important elements for service provision, not only for people living in rural and remote areas, but also as a preferred mode of treatment for some sections of the population.

A number of countries including the US and the UK have taken person-centred care or personalisation a major step forward with the introduction of personal budgets, a personal allocation of funding that allows people to have greater choice and control over whom they get to provide their support needs and how these services are provided. This approach is now being implemented within Australia and New Zealand.

3. Agreed Key Areas for Development of Principles

1. Integrated care
2. Person-centred care
3. Collaboration and partnership
4. Access to care
5. Advocacy
6. Evidence-based care
7. Physical health needs
8. Role of psychiatry in drug and alcohol dependency
9. Safety
10. Role of psychiatry in cross sector workforce development
Area 1: Integrated Care

The term *community mental health* has been used in a variety of ways:

- To describe the geographic location in which services are delivered;
- As a specialist field in its own right, underpinned by its own theoretical and practice base;
- As an element of ‘stepped’ or ‘integrated’ model of care.

It was in its recognition of the dynamic nature of the relationship between the individual and his/her socio-cultural environment that community mental health began to diverge during the 1960s/1970s from *institutional* psychiatry, which had dominated practice during the preceding 150 years. It developed in part, as a reaction to institutionally-based care and in part, as a response to changing values and attitudes within the mental health professions and the broader community where increasing emphasis was being placed on individual rights and on the modification of the environment as the primary avenue of social change.

However, community mental health services are operating in a very different environment today. There is now a complex array of primary and secondary, public, private and non-government services providing a range of treatment, psychosocial rehabilitation, support, housing, education, training, support and income support services for people with mental illness within the community setting that all have important roles to play in providing a comprehensive, recovery-orientated community mental health system.

The attendees at the Forum were of the view that the concept of community mental health, envisaged as it was historically as a specialist field, has lost its meaning in contemporary mental health and it was more meaningful to conceptualise it as a component of an *integrated system* of mental health care.

**Principle 1:** Community mental health services should be seen as an array of primary and specialist, government, non-government and private services delivered in a community setting. Specialist community mental health services can be conceptualised as one component of an *integrated system* of mental care.
Area 2: Person-centred Care

Despite major advances in mental health over the last half century, a significant proportion of service users and carers are dissatisfied with current services. They see the system as “overly biomedical orientated, disease focused, technology driven” and professionally dominated. They want to have greater choice and control over their lives and in the services they receive. And internationally, governments are heeding their call with the introduction of a policy of person-centred care or personalisation.

Person-centred care means starting with the person as an individual with strengths, preferences, aspirations, beliefs and cultural needs, family situation and lifestyle and acknowledging they are at the centre of the process of identifying their needs and making choices about how and when they are supported to live their lives. It requires a significant transformation of mental health services so that all systems, processes, staff and services are geared up to put people requiring mental health support first. The figure below depicts in diagrammatic form, the core relationships and key stakeholders in a person-centred model of care.

Person-centre Care is increasingly emerging within health, including mental health, as a spectrum of new forms of practice ranging from person-centred planning to individual budgets and direct payments to service users allowing them to choose and control their own care and support packages. The spectrum of a person-centred care service model found in practice is illustrated in the diagram below.

1 People-Centred Health Care: A Policy Framework. WHO Western Pacific Region [2007]
Amongst health services providers, psychiatrists are in a unique position with the capacity to compulsorily treat people in hospital or in the community under mental health legislation. This is restricted to situations in which there is serious risk of harm to the person or others as a result of the person’s impaired capacity associated with mental illness. So what does this mean for person-centred care?

From the service user perspective, compulsory admission, particularly a first admission can hinder their recovery, arouse fears and promote a sense of powerlessness. Fear of psychiatrist’s power has been described:

“to incarcerate, make judgements, disbelieve and dismiss people’s experience made them feel particularly vulnerable. The very professionals they needed to turn to for help were the same people that could have them forcibly admitted to hospital.”

However, in narrative reports collected in research carried out by the Scottish Recovery Network [SRN], psychiatrists were a significant feature in people’s recovery journeys. “Once trust was established, they helped people to sort out issues and were seen as a resource to the recovery process.”

In the SRN study, a number of people reported their shock at the time of being compulsorily admitted under the Mental Health Act. This related primarily to feeling uninformed, not knowing what was happening and feeling that nobody had the right to do that to them. As one person reported,

“I hated it. The first night there I was not even introduced to the night staff, I was made to queue up with everyone else in the hallway for my medication and to have a

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3 ibid
staff nurse turn to his nursing assistant and say ‘Who’s this?’ Not even introduce themselves.”

Whilst many service users and their families recognise that hospitalisation and treatment, even as an involuntary patient, may be necessary and offer opportunities for recovery, they feel that attention to the individual, their sense of self and worth is considered very important. As the SRN study found,

“It was felt that a focus on maintaining the rights and dignity of the individual throughout their stay would build on the sense of security and care people experienced and add an element of empowerment as a resource for recovery.”

There is accumulating evidence that patient-centred care brings many potential gains including increased patient safety, improved adherence to care plans, improved treatment and health outcomes, increased patient and family satisfaction with care and improved quality of life for patients and their families.

Even when people are being compulsorily detained and treated, it is important that they are given as much choice and control over what happens to them as is possible within the limits of their safety and that of others. The developments of crisis plans and advance directives with people when they are well are strategies that can be used to give people more choice and control over their lives and treatment during exacerbations of their mental health conditions.

Principle 2: Mental health services must place service users/tangata whenua and their families/whanau and carers at the centre of a patient-centred health care system and focus on personal recovery in addition to clinical outcomes.

Principle 3: Services must focus on individuals, their sense of self and worth and on maintaining their rights and dignity. Individuals/tangata whenua will be given as much choice and control over their treatment and care as is possible within the limits of their safety and that of others.

4 ibid

5 ibid
Area 3: Collaboration and Partnership

As can be seen from the figure above, community engagement and quality of life for people with mental illness often depends on a complex array of services. But the informal support given by family and friends is often the single most important factor supporting mental well-being. Families provide much of the support and care, accommodation and financial assistance that enable people with mental illness to keep functioning in the community. Frequently, however, they receive little recognition, information and support from the mental health service system for the role they play.

The fundamental change in a personalised, recovery-focused mental health system has to be with the quality of the partnership of mental health professionals with service users and carers. This partnership will bring the professional's clinical knowledge and expertise together with the individual’s own experience of his/her particular illness and with what matters most in his/her life. It will also recognise the importance of families and carers in the life of individuals and engage them in the partnership.

The psychiatrist’s role in this partnership will be more like that of an expert consultant than an authority, providing the service user and carers with the information, skills, and supports necessary to help them manage their own condition and get the best quality of life possible. Central to this role will be collaboration with the service users and their family carers in the development of their treatment plan.

In the words of Professor Stephen Leeder,

“Instead of relatively short and sharp encounters with the health service, more people are embarking upon journeys of years or decades, requiring assistance and support. … The question, then, for those interested in providing health services ….. is, what kind of services and care best fit the needs of people who are on a patient journey?”

This question is particularly pertinent in mental health where many service users are on a journey that may take them through a multitude of services including primary and specialist, public, private and non-government, community and inpatient, first episode and continuing care services over time. Furthermore community services such as income support, stable housing and education and employment may be vital to enabling people to strengthen their community engagement and improving their quality of life. Effective collaboration and improved linkages between service providers is required to ensure that people are supported on their journey of recovery. Crucially, this includes the need for government collaboration for housing and employment and education, acknowledging the need for people with severe mental illness to have support and access to meaningful employment and the requirement for safe and stable accommodation.

An important issue raised by the Community Collaboration Committee in June 2011 was the common practice of service users attending psychiatrists in private practice being denied access to allied health and nursing support from public mental health services. In a person-centred system, we need to look through the lens of each individual at the range of resources he/she needs, rather than through that of the service. Effective collaboration and partnerships between services, and particularly integration of private services within the broader mental health services, will assist in supporting individuals in their recovery journey.

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For collaboration between agencies to be meaningful and lasting, it needs to be developed at all levels, from formal agreements between agencies though to joint working of staff with service users and their families. This helps to ensure that collaboration survives individual staff changes. The development of individual treatment plans provides the mechanism for determining which agencies and staff will need to be part of the ‘team’ involved in a person’s support and care. This will clearly change from time to time depending on where the person is on their recovery journey. Care coordination is an important element in ensuring the synchronisation of this process.

**Principle 4:** A person-centred, recovery-focused mental health system must focus on the quality of the partnership of mental health professionals with service users/tangata whenua and whanau/ family and carers. This partnership will bring the professional’s clinical knowledge and expertise together with the individual’s own experience of his/her particular illness and with what matters most in his/her life. It will also recognise the importance of whanau/families and carers in the life of individuals and engage them in the partnership.

**Principle 5:** Effective collaboration and improved linkages between service providers is required to ensure that people are supported on their journey of recovery.
Area 4: Access to Care

The general community has a limited understanding of the complexity of mental illness, the services available to best meet their needs or where and how to access them. People who have not used mental health services before can find the mental health system particularly confusing and even their general practitioners can find it difficult to access mental health services. They may also experience problems with the initial response when they do contact mental health services.

Compounding problems of access, is the gross mal-distribution of psychiatrists and other health professionals throughout Australia and New Zealand, with options more limited particularly in rural and remote areas.

What service users and their families want is to have access to services (in or through a primary care setting) early in the course of their illness before what started out as a problem becomes an emergency.

It is important to have a system in place to improve the general community’s access to mental health information, referral and advice so that people can make an informed choice about what action they should take and what part of the mental health system – primary care, private or public mental health, alcohol and drug services - would best meet their needs. This also means ensuring that there is an accessible and easy front door to the specialist mental health services to ensure that people who are unwell get timely access to treatment and support.

The principle that should guide the access policy is ‘no wrong door’, an approach that provides people with, or links them to, appropriate services regardless of where they enter the system of care. This principle commits all services to respond to the individual’s stated and assessed needs through either direct service provision or through linking them to an appropriate program, as opposed to a person being referred from one agency to another. This should apply regardless of geographical location.

Principle 6: Access to Mental Health Services is founded on the principle of ‘no wrong door’, an approach that provides people with, or links them to, appropriate services regardless of where they enter the system of care.
Area 5: Evidence-based Practice [EBP]

It is 18 years now since the early papers outlining Evidence Based Medicine were published. Early proponents emphasized the “need to move beyond clinical experience and physiological principles to rigorous evaluation of the consequences of clinical actions.” Few people now would argue with the fundamental principles of EBP, although universal uptake remains a challenge in psychiatry, as indeed more broadly in healthcare.

The early development of EBP was all about research evidence and participation by service users in decision making was largely ignored. By the mid 1990s, however, the concept had been broadened to include the notion of ‘Shared Decision Making’ [SDM], which recognises the importance of service users’ values and preferences by ensuring that they have a central role in decisions about their own clinical care. Just as in the case of EBP, the uptake of SDM remains limited in practice. In fact, some practitioners argue that the two, EBP and SDP, are mutually exclusive.

So what do we mean by research evidence and what are we looking for? And what are the different kinds of knowledge and expertise that can help integrate research evidence and individual practice? Essentially, EBP is determined by outcome measures established by researchers as being desirable: but these measures may not necessarily be as highly valued by service users.

Process measures are equally important in the clinical setting. It may be, for example, that people are being prescribed a particular medication of proven efficacy, but if they are not taking their medication, treatment will not be effective. There is evidence that where people are engaged in the process and have some choice and control, they are more likely to own their treatment plan, get better clinical outcomes and be more satisfied with their care.

In addition to the knowledge and expertise that comes from research and clinical practice, we need to learn from the experience and knowledge that comes from service users and families members living with the illness and experiencing its impact on relationships and life in the community; and we need to understand the impact of customary and traditional knowledge, particularly in our aboriginal people and people from other cultures.

At the heart of EBP is the clinical consultation. Integrating the evidence and the service user’s preference is recognised as a key component of EBP and involves two steps. The first task requires the doctor to take the research evidence and individualise it, while the second is to communicate the evidence to the patient. The tasks are outlined in the diagram below.

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Principle 7: Evidence-based practice should be the corner-stone of mental health services. Integrating the research evidence and the tangata whenua/service user’s preferences need to be seen as an integral part of Evidence-based Practice.
Area 6: Advocacy

In research conducted by the Department of Health in the UK in 2010\(^8\) surveying public attitudes to people with mental illness, respondents believed that 36% of people with mental illness were prone to violence, 48% believed they could not be held responsible for their own actions, 57% said they needed to be kept in hospital and 25% thought they did not have the same right to a job as anyone else.

In their study of ‘People Living with Psychotic Illness’,\(^9\) Jablensky and his colleagues found that 45% were living in institutions, hostels, group homes or were homeless. The ABS Survey of Disability, Ageing and Carers [1998] reported high levels of unemployment for people with a mental illness [Waghorn, 2005]\(^10\).

<table>
<thead>
<tr>
<th>Persons aged 15-64 years in 1998</th>
<th>Not in the labour Force (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Australians</td>
<td>19.9</td>
</tr>
<tr>
<td>Anxiety disorders (ICD-10)</td>
<td>47.1</td>
</tr>
<tr>
<td>Depression (ICD-10 excluding post-natal)</td>
<td>56.4</td>
</tr>
<tr>
<td>Bipolar affective disorder (DSM-III-R, most with psychotic features)</td>
<td>61.8</td>
</tr>
<tr>
<td>Psychotic disorders (DSM-III-R)</td>
<td>75.2</td>
</tr>
<tr>
<td>Schizophrenia (DSM-III-R)</td>
<td>80.7</td>
</tr>
</tbody>
</table>

It is clear that there is still considerable community misunderstanding and stigma associated with mental illness and that many people who suffer from a mental illness experience high levels of social exclusion. There are strong linkages between poverty, poor education, unemployment and inadequate housing/homelessness and poor general and mental health. Good mental health care alone is not sufficient in promoting personal recovery in people with mental illness. As Thompson writes:

> “Promoting tolerance and community acceptance of persons with a psychiatric disorder, although necessary, is no longer sufficient. We need to .... [promote] “social Inclusion” .... [which] requires that society and its institutions actively promote opportunities for the participation of excluded persons, including persons with psychiatric disabilities, in mainstream social, economic, educational, recreational and cultural resources.”\(^{11}\)

\(^8\) Attitudes to Mental Illness 2010 Research Report JN207028. Department of Health UK


Mental health practitioners, including psychiatrists, must continue to work *in partnership* with service users and service user and family/carer groups to support advocacy, not only for improved mental health services but for a reduction in stigma associated with mental illness and for their best recovery.

In the section on person-centred care, it was recognised that there is a significant power imbalance between staff and service users; particularly in the case of psychiatrists when they hold the power for compulsory admission and treatment. Service users have a right to be able to access independent advocates, his needs to be not only recognised but supported.

**Principle 8:** Psychiatrists, must continue to work *in partnership* with tangata whenua/service users and whanau/family/carer groups to support improved mental health services and a reduction in stigma associated with mental illness and for the best recovery possible.

**Principle 9:** Mental health services must ensure that tangata whenua/service users and whanau/families/carers have access to independent advocacy.
Area 7: Physical Health Needs

The issue of protection and promotion of physical health in people with severe mental illness is a major public health and ethical issue. There is extensive research evidence that:

- the prevalence of many physical diseases is higher in people with severe mental illness than in the general population;
- the gap between the prevalence of some of these diseases in people with mental illness and the general population has been increasing in the past few decades;
- the co-existence of one or more physical diseases has a significant impact on their quality of life;
- mortality due to physical diseases is higher in people with mental illness;
- access to physical health is reduced compared to the general population; and
- the quality of physical health care received is poorer than for the general population.

In order to address this situation, a number of strategies have been identified:

- Raising awareness of the problem among mental health professionals, primary care practitioners, patients and their families is obviously a priority;
- Education and training of mental health professionals and primary care providers – there is a role for psychiatry in helping train primary care professionals and physicians;
- Overcoming the reluctance of medical practitioners to treat people with severe mental illness, which is not so much an issue of knowledge and skills as of attitude;
- There always needs to be an appropriately trained professional who is identified as responsible for the person's physical health care;
- Mental health services should be able to provide a standard routine physical assessment of their patients in an inpatient setting in a community mental health setting, weight, height, waist circumference and BP and taking systematic enquiry about physical function should be provided as part of a comprehensive psychiatric assessment.
- Currently available guidelines about the choice of antipsychotic medication as regards physical health risks and benefits, in the individual patient and the management of patients receiving antipsychotics should be known and applied by all mental health services;
- Mental health professionals should encourage patients to monitor and chart their own weight and should sensitize patients and their caregivers to the health risk associated with excess weight;
- Dietary and exercise programs should be an essential part of care plans; and
- Further research in this area is urgently required.

The promotion of physical health care in people with severe mental illness is a key issue requiring urgent attention. Unless we regard it as a priority, we will not be able to convincingly state that we are striving towards an improved quality of life and the protection of the civil rights of our patients.

Principle 10: The physical care of tangata whenua/individuals with mental illness needs to be seen as a critical challenge requiring urgent attention. Mental health services need to have policies and strategies in place and strong partnerships with primary care to ensure physical health needs are addressed.
Area 8: Role of Psychiatry in Drug and Alcohol Misuse

Providing effective assessment, treatment services and care to someone with a mental illness and alcohol and/or other drug use problems is a significant challenge facing frontline health care workers. Evidence suggests that some health professionals are unprepared when it comes to conducting detailed assessments, preparing case plans or working with people with the co-occurring problems. The separation of alcohol and drug services from mental health services was largely philosophically and politically driven and does not therefore reflect the actual needs of those requiring treatment and support.

Yet co-morbidity is extremely common. Jablensky et al,\textsuperscript{12} in their study of low prevalence disorders as part of the National Survey of Mental Health and Well-being [1999] found that the life-time prevalence of both alcohol abuse/dependence and abuse/dependence on other drugs in men was just under 40\%, much higher than in the general population. Similarly, studies of people presenting with substance abuse disorders have found that around one third have some form of mental disorder.

Substance abuse disorders amongst people with mental health disorders have been associated with significantly poorer outcomes including increased relapse, increased use of institutional services, poor medication compliance, increased homelessness, increased risky behaviours, poor social outcomes, increased suicidal behaviour and increased contact with the criminal justice system. The provision of integrated care is essential to enable the delivery of effective treatment for this group of people. Integrated care entails the coordination of interactions and relationships within and across services in order to secure the best possible service system response. It does not necessarily imply the structural realignment of service systems.

It is important that service users are not bounced between services. At the service level, a core feature of integrated care is the provision of mental health and substance use services in a single setting wherever possible, and if not, then linkage between services via agreed clinical pathways.

At the systems level, it entails a focus on the provision of holistic and coordinated care, liaison and advice and the development of clinical pathways across a range of government, non-government and private agencies. Some of the more successful collaborations between mental health and drug and alcohol services have involved dual diagnosis training programs for staff. Given the level of co-morbidity in mental health there is a strong argument for increased training of psychiatrists in addictions.

Principle 11: Providing effective assessment, treatment services and care to tangata whenua/people with alcohol and/or other drug use problems and a mental illness requires a system level response focused on coordination and clinical pathways across a range of government, non-government and private agencies.

Area 9: Safety

An important issue brought into focus by the shift towards individuals having more responsibility and control over their own lives is safety - and its counterpart, risk. The mental health system is currently going through a period where political and community attitudes and values have produced an environment that is strongly risk averse. While recognising that people must be able to be cared for and work in safe environments, there needs to be recognition and an understanding that risks to safety and unpredictability are inherent in the mental health sector.

In order to reduce the occurrence of suicide, current risk assessment methods in mental health focus on predicting individual suicide generally by classifying people as high, medium or low risk. Several key factors are used as potential indicators of suicide risk, including the presence of mental illness, in particular a depressive disorder, previous attempts of suicide, self harm, substance abuse, lack of family support and adequate means to commit suicide. Unfortunately, there is no current rating scale or clinical algorithm that has proven predictive value in the clinical assessment of suicide risk and there is no evidence that risk prediction is accurate or prevents suicide. Most people who commit suicide are low risk and few high risk people complete suicide. Recent studies have shown that 3% of those who commit suicide are categorised as high risk, and 60 % of those who committed suicide were in the low-risk category. Similarly, the prediction of violence and aggression within mental health care settings has proven to be of little predictive value.

An alternative approach is risk management, which is not aimed at predicting risk but at identifying both historical and dynamic risk factors and managing modifiable risk factors in the patient, the clinician and the system.

The environment of risk aversion is problematic, because people need to take responsibility to grow, develop and change. In life, taking risks is a necessary part of being human. Risk can, therefore, be something necessary or something to manage or avoid. In a recovery-oriented service, the line between the two is not always easy to navigate. This has given rise to the concept of harmful risk versus positive risk-taking.

Harmful risk relates to behaviours which are illegal, not socially sanctioned or damaging to the health and safety of the person or others [e.g. homicidal and suicidal acts, anti-social and criminal behaviour, personal irresponsibility, self-harming patterns of behaviour]. Harmful risk is to be avoided where possible and treatment goals focus on reducing or managing harmful risk.

Positive risk-taking relates to behaviours which involve the person taking on challenges leading to personal growth and development. This includes developing new interests, trying something that is a challenge to achieve, deciding to act differently in a relationship and taking on new roles. There is nearly always benefit from this, even if it all goes wrong. Resilience is developed through trying and failing. Positive risk-taking will be needed to meet many recovery goals. Managing the line between risk avoidance and ‘positive’ risk taking should be integrated into evidence-based practice.

Services need to be aware that an undue focus on harmful risk avoidance through staff action creates a culture which may reduce the extent to which people develop skills in taking responsibility for their own actions.

Principle 12: Risk management procedures within mental health services should have an approach that focuses on managing modifiable risk factors in the patient, the clinician and the system.

Principle 13: In a recovery-orientated service, the line between risk avoidance and ‘positive’ risk taking is not always easy to navigate; to help manage this risk management and assessment should be an integrated part of evidence based practice.
Area 10: Workforce

We are on the cusp of a significant transformation of the current mental health workforce with:

- Government support and funding for an increased role of community sector organisations [NGOs] in mental health service provision;
- Growth in the role of Allied Health practitioners in the provision of mental health services: and, in Australia, growth in the private sector through access to Medicare with programs such as Better Access and Access to Allied Psychological Services;
- An expanded role for nurses through the training of Nurse Practitioners;
- Building the capacity of primary care practitioners to be able to manage the needs of people with mild to moderate mental health problems;
- Growth in the number of health workers with a lived experience of mental ill-health to act as Peer Professionals; and
- Introduction of new classes of workers like Personal Helpers and Mentors.
- Signalling of the development in other new classes of workers by Governments.

What does this newly emerging 'landscape of changes to mental health services mean for psychiatrists in Australia and New Zealand? These changes cannot be controlled by the College, but understanding them can enable the College to play a major part leading change.

The Board of Practice and Partnerships is about to embark on a major project aimed at defining the role for psychiatrists in contemporary practice. This is important for a number of reasons, including:

- To inform governments, health service providers and others about role of psychiatrists within the mental health system;
- To ensure that our members are fully cognizant of the very significant changes taking place in the mental health system and to help them understand and adapt to what is required of them now and into the future; and
- To help shape the recruitment and training of future generations of psychiatrists.

To achieve its objectives, the project will produce an Occasional Paper.

**Principle 14: The College will define the role of a psychiatrist in contemporary and developing mental health practice.**

*Adopted: February 2012 (GC2012/1. R37)*

*Currency: Reviewed every 3 years (next review May 2015)*

*Owned by: Committee for Professional Practice*
Appendix 1

Attendees: 
Dr Darryl Watson, Chair
Dr Mat Coleman
Dr Rosie Edwards
A/Prof Stephen Macfarlane
A/Prof Richard Newton
Dr Sue Nightingale
Prof Mark Oakley Browne
Ms Kali Paxinos
Mr Graham Roper
Dr James Scott
A/Prof Geoff Smith
Dr Peter Tylis
Dr Murray Wright

In Attendance: 
Dr Anne Ellison
Ms Sylvia Daravong